520 – MEMBER TRANSITIONS

EFFECTIVE DATES: 10/01/94, 07/01/16, 10/01/17

REVISION DATES: 07/22/96, 02/01/01, 10/01/01, 04/01/05, 11/01/07, 03/01/11, 11/03/16, 06/01/17

I. PURPOSE

This Policy applies to Acute Care, ALTCS E/PD, CRS, DCS/CMDP, DES DDD, and RBHA Contractors; Fee-For-Services (FFS) Programs as delineated within this policy including: Tribal ALTCS, TRBHAs, the American Indian Health Program (AIHP); and all FFS populations, excluding Federal Emergency Services (FES). (For FES, see AMPM Chapter 1100). This Policy establishes guidelines for Contractors and FFS Programs regarding member transitions.

II. DEFINITIONS

CUSTOMIZED DME — Equipment that has been altered or built to specifications unique to a member's medical needs and which, most likely, cannot be used or reused to meet the needs of another individual.

ENROLLMENT TRANSITION INFORMATION (ETI) — Member specific information the Relinquishing Contractor must complete and transmit to the Receiving Contractor or FFS Program for those members requiring coordination of services as a result of transitioning to another Contractor or FFS Program.

MEMBER TRANSITION — The process during which members change from one Contractor or FFS Program to another.

III. POLICY

A. MEMBER TRANSITIONS

Contractors shall identify and facilitate coordination of care for all AHCCCS members during transitions between Contractors, FFS Programs, FFS members transitioning to an MCO, as well as changes in service areas, subcontractors, and/or health care providers. Members with special circumstances may require additional or distinctive assistance during a period of transition. Policies and procedures shall be developed to address these situations.

Special circumstances include members designated as having "special health care needs" under AMPM Policy 540 including but not limited to the following:

1. Pregnancy (especially women who are high risk or in their third trimester),

2. Major organ or tissue transplantation services which are in process,

3. Chronic illness, which has placed the member in a high-risk category and/or resulted in emergency department utilization, hospitalization or placement in nursing, or other facilities, and/or

4. Significant medical or behavioral health conditions (e.g., diabetes, asthma, hypertension, depression, or serious mental illness) that require ongoing specialist care and appointments,

5. Chemotherapy and/or radiation therapy,

6. Dialysis,

7. Hospitalization at the time of transition,

8. Members with ongoing needs such as:
   a. Durable medical equipment including ventilators and other respiratory assistance equipment,
   b. Home care services, such as Attendant Care or Home Health,
   c. Medically necessary transportation on a scheduled and/or ongoing basis,
   d. Prescription medications (including those that have been stabilized through a step therapy process), and
   e. Pain management services.

9. Members who frequently contact AHCCCS, State and local officials, the Governor's Office and/or the media,

10. Members enrolled with Division of Child Safety/Comprehensive Medical and Dental Program (CMDP),

11. Members identified as a High Need/High Cost member,

12. Members on conditional release from Arizona State Hospital,

13. Other services not indicated in the State Plan for eligible members, but covered by Title XIX and Title XXI for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) eligible members, including members whose conditions require ongoing monitoring or screening.

    Members who at the time of their transition have received prior authorization or approval for:
    a. Scheduled elective surgery(ies),
    b. Procedures and/or therapies to be provided on dates after their transition, including post-surgical follow-up visits,
    c. Sterilization and have a signed sterilization consent form, but are waiting for expiration of the 30-day period,
    d. Behavioral health services,

e. Appointments with a specialist located out of the Contractor service area, and
f. Nursing facility admissions.

For Contractor Requirements for member transitions between AHCCCS Contractors for Annual Enrollment Choice (AEC) and eligibility changes see ACOM Policy 402.

B. NOTIFICATIONS REQUIRED OF CONTRACTORS

1. Relinquishing Contractors shall provide relevant information regarding members who transition to a receiving Contractor or a FFS Program. The ETI Form shall be utilized for transfer of information for at least those members with special circumstances, listed in this Policy who are transitioning enrollment to another Contractor or a FFS Program. There are two specific ETI forms:
   a. AMPM Policy 520, Attachment A, and
   b. AMPM Exhibit 1620-9 Arizona Long Term Care System (ALTCS) Enrollment Transition Information Form is used by ALTCS Contractors.

2. The relinquishing Contractor must complete and transmit the ETI to the appropriate parties no later than 10 business days of receipt of AHCCCS notification.

3. For individuals determined to have a Serious Mental Illness (SMI) who are transitioning from a Contractor to a Regional Behavioral Health Authority (RBHA) for provision of physical health services, there shall be a 14 day transition period in order to ensure effective coordination of care.

4. Relinquishing Contractors who fail to notify the receiving Contractor or FFS Program of transitioning members with special circumstances will be responsible for covering the members' care for up to 30 days following the transition.

5. Contractors shall provide protocols for the transfer of pertinent medical records, as discussed in this Policy, and arrange for the timely notification to members, subcontractors or other providers, as appropriate during times of transition.

6. Receiving Contractors shall provide new members with a member handbook, provider directory, and emergency numbers as specified in Contract.

7. Receiving Contractors or FFS Programs shall follow-up as appropriate for the needs identified on the ETI form.

C. TRANSITION TO ALTCS

If a member is referred to and approved for ALTCS enrollment, the relinquishing Contractor shall coordinate the transition with the receiving ALTCS Contractor or Tribal ALTCS.

The Contractors shall ensure applicable protocols are followed for any special circumstances of the member, and that continuity and quality of care is maintained during and after the transition.

Refer to ACOM Policy 402 and AMPM Policy 1620 for ALTCS Contractor responsibilities in the transition process.

D. TRANSITION FROM CHILD TO ADULT BEHAVIORAL HEALTH SERVICES

The transition into the adult behavioral health system must begin for any child involved in behavioral health care when the child reaches the age of 16. Planning must begin immediately for youth entering behavioral health care at 16 years of age or older.

A transition plan that starts with an assessment of self-care and independent living skills, social skills, work and education plans, earning potential and psychiatric stability must be incorporated in the child's Service Plan).

For children who transfer to the adult SMI or General Mental Health/Substance Use system, Contractors and providers serving the FFS population must develop a process and procedure to ensure and support the delivery of children and adult services during the transition period.

Contractors shall ensure that adult system staff attend and participate in the Child and Family Team (CFT) and/or treatment team service planning process beginning four to six months prior to the child turning 18. Providers serving the FFS population shall coordinate the member's transition with the assigned TRBHA or Tribal ALTCS case manager. For guidance related to transition planning refer to the AHCCCS Transition to Adulthood Practice Tool.

Contractors and providers serving the FFS population shall ensure members receiving behavioral health services are evaluated when they reach the age of 17 to determine if they may be eligible for services as an adult with a SMI. If so, the member shall be referred for an SMI eligibility determination. See AMPM Policy 320-P. For guidance related to referring the member for SMI determination, refer to the AHCCCS Transition to Adulthood Practice Tool.

E. MEMBERS HOSPITALIZED DURING AN ENROLLMENT CHANGE

Contractors shall make provisions for the transition of care for members who are hospitalized on the day of an enrollment change. The provisions shall include processes for the following:

1. Authorization of treatment by the receiving Contractor or FFS Program.

2. Reimbursement as outlined in the AHCCCS All Patient Refined Diagnosis Related Groups (APR-DRGs) Payment System Design Payment Policies on the AHCCCS website.

3. Notification to the hospital and attending physician of the transition by the relinquishing Contractor. The relinquishing Contractor shall notify the hospital and attending physician of the pending transition prior to the date of the transition and instruct the providers to contact the receiving Contractor or FFS Program for

authorization of continued services. If the relinquishing Contractor fails to provide notification to the hospital and the attending physician relative to the transitioning member, the relinquishing Contractor shall be responsible for coverage of services rendered to the hospitalized member for up to 30 days. This includes, but is not limited to, elective surgeries for which the relinquishing Contractor *issued* prior authorization.

4. Coordination with providers regarding activities relevant to concurrent review and discharge planning shall be addressed by the receiving Contractor or FFS Program.

   See AMPM Policy 530 for transfers between hospitals.

F. TRANSITION DURING MAJOR ORGAN AND TISSUE TRANSPLANT SERVICES

1. If there is a change in Contractor or FFS enrollment, both the relinquishing and receiving Contractors and/or FFS Program are responsible for coordination of care and coverage for members who have been approved for major organ or tissue transplant. The relinquishing Contractor or FFS Program is responsible for contracted components up to and including, completion of the service components that the member is receiving at the time of the change. The receiving Contractor or FFS Program is responsible for the remainder of the components of the transplant.

2. If a member changes to a different Contractor while undergoing transplantation at a transplant center that is not an AHCCCS contracted provider, each Contractor is responsible for its respective dates of service. If the relinquishing Contractor has negotiated a special rate, it is the responsibility of the receiving Contractor to coordinate the continuation of the special rate with the respective transplant center.

G. ENROLLMENT CHANGES FOR MEMBERS RECEIVING OUTPATIENT TREATMENT FOR SIGNIFICANT MEDICAL CONDITIONS

1. Contractors shall have protocols for ongoing care of members with active and/or chronic special health care needs (e.g., outpatient chemotherapy, home dialysis, behavioral health needs, and pregnancy) during the transition period. The receiving Contractor shall have protocols to address the timely transition of the member from the relinquishing Primary Care Provider (PCP) to the receiving PCP, in order to maintain continuity of care.

2. Pregnant women who transition to a new Contractor within the last trimester of their expected date of delivery shall be allowed the option of continuing to receive services from their established physician and anticipated delivery site.

H. TRANSITION OF MEDICALLY NECESSARY TRANSPORTATION

Contractors shall have processes for at least the following:

1. Information to new members on what, and how, medically necessary transportation can be obtained, and

2. Information to providers on how to order medically necessary transportation.

I. TRANSITION OF PRESCRIPTION MEDICATION SERVICES

Contractor shall address the dispensing and refilling of prescription medications during the transition period as follows:

1. The relinquishing Contractor shall cover the dispensation of the total prescription amount of either continuing or time-limited medications, if filled at or before midnight on the last day of enrollment. The relinquishing Contractor may not reduce the quantity of the ordered prescription unless it exceeds a 30-day supply or 100 unit doses.

2. The receiving Contractor or FFS Program shall extend previously approved prior authorizations for a period of 30 days from the date of the member's transition unless a different time period is mutually agreed to by the member or member's representative.

3. Members transitioning from a BHMP to a PCP for behavioral health medication management shall continue on the medication(s) prescribed by the BHMP until the member can transition to their PCP. Contractors shall coordinate the care and ensure that the member has a sufficient supply of behavioral health medications to last through the date of the member's first appointment with their PCP. Members receiving behavioral health medications from their PCP may simultaneously receive counseling and other medically necessary services from the RBHA.

4. A person receiving methadone administration services who is not a recipient of take-home medication may receive up to two courtesy doses of methadone from a RBHA Contractor while the person is traveling out of the service area of the assigned RBHA Contractor.
   a. All incidents of provision of courtesy dosing must be reported to the assigned RBHA or TRBHA or Tribal ALTCS case manager.
   b. The assigned RBHA Contractor must reimburse the RBHA Contractor providing the courtesy doses upon receipt of properly submitted bills or encounters.
   c. Indian Health Services and Tribally owned or operated 638 facilities should refer to Chapter 12 of the IHS/Tribal Provider Manual for Methadone Administration Guidelines.
   d. Providers serving the FFS population should refer to Chapter 19 of the Fee-For-Service Provider Manual for Methadone Administration Guidelines.

Refer to AMPM Chapter 300 in this Manual for complete information regarding prescription medication coverage.

J. DISPOSITION OF DURABLE MEDICAL EQUIPMENT AND OTHER MEDICAL SUPPLIES DURING TRANSITION

Contractors and Tribal ALTCS shall address the disposition of Durable Medical Equipment (DME) and other medical equipment during a member's transition period and develop policies that include the following:

1. Non-customized DME

   The relinquishing Contractor and Tribal ALTCS shall provide adequate information about members with ongoing DME needs to the receiving Contractor and/or FFS Programs.

2. Customized DME:
   a. Customized DME purchased for members by the relinquishing Contractor will remain with the member after the transition. The cost of the equipment is the responsibility of the relinquishing Contractor,
   b. Customized DME ordered by the relinquishing Contractor but delivered after the transition to the receiving Contractor shall be the financial responsibility of the relinquishing Contractor, and
   c. Maintenance contracts for customized DME purchased for members by a relinquishing Contractor will transfer with the member to the new Contractor. Contract payments due after the transition will be the responsibility of the receiving Contractor, if the receiving Contractor elects to continue the maintenance contract. For FFS Programs, FFS Program rates apply.

3. Augmentative Communication Devices (ACDs):
   a. A 90 day trial period is generally necessary to determine if the ACD will be effective for the member, or if it should be replaced with another device,
   b. If a member transitions from a Contractor during the 90 day trial period, one of the following shall occur:
      i. If the ACD is proven to be effective, the device remains with the member. Payment for the device is the responsibility of the relinquishing Contractor. The cost of any maintenance contract necessary for the ACD shall be the responsibility of the receiving Contractor, if the receiving Contractor elects to continue the maintenance contract. For FFS Programs, FFS Program rates apply, or
      ii. If the ACD is proven to be ineffective, it is returned to the relinquishing Contractor. The receiving Contractor shall reassess the member's medical condition and purchase a new device if it is determined to be potentially effective in meeting the member's needs.

   NOTE: If the member has had the ACD for more than a 90 day trial period, the Customized DME process in section 2 above applies.

K. MEDICAL RECORDS TRANSFER DURING TRANSITION

To ensure continuity of member care during the time of enrollment change, Contractors shall ensure timely medical records. Refer to AMPM Policy 940 for additional information.

L. RBHA REFERRALS RESULTING IN OUT OF SERVICE AREA PLACEMENT

1. When a RBHA initiates a referral for placement of an integrated member with SMI or any non-integrated member to a service provider in another RBHA's service area for

the purposes of obtaining behavioral health services, the resulting relocation of the member may result in the eligibility source making corresponding changes to a member's address in the PMMIS. A change of address to another GSA will cause the integrated SMI member to become enrolled with a RBHA in the other GSA for both behavioral health and physical health services. A change of address to another GSA will cause a non-integrated member to become enrolled with an Acute Care Contractor in the other GSA for physical health services and assigned to the RBHA in the other GSA for behavioral health services.

2. The RBHA who made the referral for the out of area placement shall take steps to ensure retention of the member's behavioral health assignment as well as financial responsibility for behavioral health services for non-integrated members, and in the case of an integrated SMI member, of the members behavioral assignment and physical health enrollment as well as financial responsibility for both behavioral and physical health services during the period the member is placed out of the RBHA's service area:
   a. The referring RBHA is responsible for completing and submitting an Out of Area Placement Request utilizing Attachment B of this Policy to ensure AHCCCS is aware of and can flag the member in the AHCCCS system as being in an out of area placement,
   b. AHCCCS will utilize the submitted documentation to update the member's record with an indicator that will bypass the automatic PMMIS changes to the member's behavioral health assignment and if an integrated SMI member, physical health enrollment. The normal automatic activation would otherwise change a member's behavioral health assignment and physical health enrollment (for an integrated SMI member), due to an out-of-GSA address change, and
   c. The referring RBHA is responsible for submitting Attachment B in its entirety and for **any** extension or change to the effective date of placement and/or end date of placement to ensure that the indicator remains in effect only as appropriate.

3. When a member is placed in an out of area placement the referring RBHA shall establish contracts with out-of-area service providers for behavioral health and physical health (for Integrated SMI members) services and authorize payment for behavioral health and physical health (for Integrated SMI members) services.

4. When the member returns to the original service area and another address change is processed in the PMMIS, the end date of the out of area placement will allow resumption of normal behavioral health assignment and physical health enrollment rules.

5. When a TRBHA initiates a referral for placement outside of the TRBHA zip codes for the purposes of obtaining behavioral health services, the resulting relocation of the member may result in the eligibility source making corresponding changes to a member's address in the PMMIS. The TRBHA with which the member is assigned may utilize the steps outlined above to ensure retention of the member's behavioral health assignment (as well as maintain financial responsibility for behavioral health services with DFSM) for the member during the period the member is out of the TRBHA's service area.